

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045765

Facility Name: Nature Trail HealthCare Center

Address: 1001 South 34th street Mt. Vernon 62864  
Number City Zip Code

County: Jefferson

Telephone Number: 618-242-5700 Fax # 618-242-5705

IDPA ID Number: 38-1923423001

Date of Initial License for Current Owners: 06/07/1994

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:  
Name: Sherry DeBons Telephone Number: (281) 579-5022

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the  
State of Illinois, for the period from 01/01/2002 to 12/31/2002  
and certify to the best of my knowledge and belief that the said contents  
are true, accurate and complete statements in accordance with  
applicable instructions. Declaration of preparer (other than provider)  
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information  
in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) Linda Holtzscheiter	
	(Title) Reimbursement Manager	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) N/A	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Nature Trail HealthCare Center

# 0045765 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds March 1,2002

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1	<u>19</u>	Skilled (SNF)	<u>19</u>	<u>5,814</u>
2		Skilled Pediatric (SNF/PED)		
3	<u>55</u>	Intermediate (ICF)	<u>55</u>	<u>21,196</u>
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Public Aid Recipient	Private Pay	Other	Total	
8 SNF	<u>125</u>	<u>32</u>	<u>2,567</u>	<u>2,724</u>	8
9 SNF/PED					9
10 ICF	<u>17,991</u>	<u>3,150</u>	<u>3</u>	<u>21,144</u>	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	<u>18,116</u>	<u>3,182</u>	<u>2,570</u>	<u>23,868</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.37%

D. How many bed-hold days during this year were paid by Public Aid? 118 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 06/07/1994

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 06/07/1994 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 19 and days of care provided 2,567

Medicare Intermediary AdminStar Illinois

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number      Nature Trail HealthCare Center      #      0045765      Report Period Beginning:      01/01/2002      Ending:      12/31/2002

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	116,209	8,097	5,238	129,544		129,544		129,544			1
2	Food Purchase		93,456		93,456		93,456	(1,645)	91,811			2
3	Housekeeping	65,844	7,400	39	73,283		73,283		73,283			3
4	Laundry	28,145	7,194		35,339		35,339		35,339			4
5	Heat and Other Utilities			56,912	56,912		56,912	13	56,925			5
6	Maintenance	41,357	20,645	4,416	66,418		66,418	36	66,454			6
7	Other (specify):*      Waste/ garbage -See Pg 3.1			19,577	19,577		19,577		19,577			7
8	<b>TOTAL General Services</b>	251,555	136,792	86,182	474,529		474,529	(1,596)	472,933			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	793,751	55,745	12,975	862,471		862,471	10,308	872,779			10
10a	Therapy	99,955	1,753	1,284	102,992		102,992		102,992			10a
11	Activities	29,863	1,759	3,326	34,948		34,948		34,948			11
12	Social Services	16,379	10	3,610	19,999		19,999		19,999			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	939,948	59,267	27,195	1,026,410		1,026,410	10,308	1,036,718			16
	<b>C. General Administration</b>											
17	Administrative	59,435			59,435		59,435		59,435			17
18	Directors Fees											18
19	Professional Services			1,408	1,408		1,408	3,268	4,676			19
20	Dues, Fees, Subscriptions & Promotions			14,453	14,453		14,453	(701)	13,752			20
21	Clerical & General Office Expenses	75,107	7,155	105,877	188,139		188,139	(33,562)	154,577			21
22	Employee Benefits & Payroll Taxes			253,705	253,705		253,705		253,705			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,383	13,383		13,383	5,753	19,136			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,523	57,523		57,523	301	57,824			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	134,542	7,155	446,349	588,046		588,046	(24,941)	563,105			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,326,045	203,214	559,726	2,088,985		2,088,985	(16,229)	2,072,756			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			48,343	48,343		48,343	82,719	131,062			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			19,458	19,458		19,458		19,458			33
34	Rent-Facility & Grounds							1,016	1,016			34
35	Rent-Equipment & Vehicles							2,321	2,321			35
36	Other (specify):* See Pg 4.1			(1,150,182)	(1,150,182)		(1,150,182)	1,155,492	5,310			36
37	TOTAL Ownership			(1,082,381)	(1,082,381)		(1,082,381)	1,241,548	159,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,104		97,104		97,104		97,104			39
40	Barber and Beauty Shops			8,238	8,238		8,238	(8,238)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):* See Pg 4.1		2,262	4,855	7,117		7,117		7,117			43
44	TOTAL Special Cost Centers		99,366	53,608	152,974		152,974	(8,238)	144,736			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,326,045	302,580	(469,047)	1,159,578		1,159,578	1,217,081	2,376,659			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,645)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds	1	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,120)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,281)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	1,187,346			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,118,301		\$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	98,780		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 98,780		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ 1,217,081		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Taxes	\$ (1,263)	21	1
2	Small Balance Adjustments	0	21	2
3	Memorium/ Benevolance	(45)	21	3
4	Depreciation Reconciliation	83,070	30	4
5	Activities Program Receipts	0	11	5
6	Depreciation Reconciliation	(351)	30	6
7	Professional Liability Insurance	68	26	7
8	Barber & Beauty	(8,238)	40	8
9	Public Relation Expense	(117)	20	9
10	Non Allowable Advertising	(1,030)	20	10
11	Entertainment	(19)	24	11
12	Fresh Start	1,150,182	36	12
13	Other direct Expenses -Marketing Operations	(1,979)	21	13
14	Vending Reciepts	0	21	14
15	Misc Reciepts	0	21	15
16	Marketing Wages	(27,369)	21	16
17	Marketing Bonus	(3,733)	21	17
18	Marketing Holiday	(626)	21	18
19	Marketing Sick	0	21	19
20	Marketing Vacation	(1,204)	21	20
21	Marketing Overtime	0	21	21
22	Legal Fees -Bankrupcty	0	21	22
23			21	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,187,346		49



## Summary B

12/31/2002

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attached page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Mariner Health Care	100.00%	\$ 13	\$ 13	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	36	36	2
3	V	19	Professional Services		Mariner Health Care	100.00%	3,268	3,268	3
4	V	20	Fees, Subscription, Promotions		Mariner Health Care	100.00%	446	446	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	10,308	10,308	5
6	V	21	Clerial & General Office Exp		Mariner Health Care	100.00%	70,057	70,057	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	5,772	5,772	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	132	132	8
9	V	36	Depreciation		Mariner Health Care	100.00%	5,157	5,157	9
10	V	36	Taxes - Property		Mariner Health Care	100.00%	153	153	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	2,321	2,321	11
12	V	34	Lease Expense		Mariner Health Care	100.00%	1,016	1,016	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	101	101	13
14	Total			\$			\$ 98,780	\$ * 98,780	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Nature Trail HealthCare Center # 0045765 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Mariner Health Care  
Street Address One Ravine Dr. Suite 1500  
City / State / Zip Code Atlanta, GA 30346  
Phone Number (770) 379-8203  
Fax Number (770) 399-1971

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities				\$ 192	\$		\$ 13	1
2	6	Repair & Maintenance				556			36	2
3	19	Professional Services				50,336			3,268	3
4	20	Fees, Subscription, Promotions				6,593			446	4
5	10	Nursing & Medical Records				675,703			10,308	5
6	21	Clerial & General Office Exp				527,522			70,057	6
7	24	Travel & Seminar				84,515			5,772	7
8	26	Insurance Premium				2,427			132	8
9	36	Depreciation				81,021			5,157	9
10	36	Taxes - Property				2,346			153	10
11	35	Rental & Leasing				35,937			2,321	11
12	34	Lease Expense				15,801			1,016	12
13	26	Property Insurance				1,581			101	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,484,530	\$		\$ 98,780	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$ \_\_\_\_\_     Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	20,283	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	19,329	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(954)	3	
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	20,413	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	19,458	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1997	18,818	8		
	1998	19,518	9		
	1999	19,647	10		
	2000	19,494	11		
	2001	19,329	12		
<b>Line 1 adjusted or not equal to prior C/R due to intercompany entries.</b>					

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail HealthCare Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0045765

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE 281-579-5022 FAX #: 281-578-4779

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 06-36-327-006	77-1-079-04 PT NE SW-BEG 330.6"	\$ 19,328.56	\$ 19,328.56
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 19,328.56	\$ 19,328.56

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

17,558

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	225,000	1994	\$ 50,246	1
2					2
3	TOTALS	225,000		\$ 50,246	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74		1994		\$ 2,213,241	\$ 63,235	35	\$ 63,235	\$	\$ 541,892	4
5			1994		329,317	16,465	20	16,465		140,526	5
6											6
7											7
8											8
	Improvement Type**										
9	Interior Building Improvement			1995	2,325	233	20	233		1,729	9
10	Unit Heaters			1996	642	64	20	64		410	10
11	Flooring - tile			1996	2,384	119	20	119		735	11
12	Heater BaseBorad - 6			1996	502	50	20	50		303	12
13	Drapes/ Valances			1996	3,956	396	20	396		2,376	13
14	Smoke Setectors			1996	2,880	288	20	288		1,794	14
15	Side rails			1996	1,149	57	20	57		308	15
16	Parking Repairs			1997	1,923	96	20	96		507	16
17	Wall Covering			1997	897	45	20	45		256	17
18	Gutters			1997	2,290	115	20	115		594	18
19	Beauty Salon			1997	1,040	52	20	52		274	19
20	Sewer Tile			1997	1,575	79	20	79		467	20
21	A/C Heater Unit			1997	591	59	20	59		303	21
22	Water Heater			1997	388	19	20	19		95	22
23	Floor Preparation			1997	650	33	20	33		191	23
24	Floor Covering			1997	1,460	73	20	73		424	24
25	Floor Finishing			1997	250	13	20	13		75	25
26	Water Heater			1997	388	39	20	39		201	26
27	Rebuilding Bathroom			1997	3,825	191	20	191		986	27
28	Cabinets / Millwork			1998	161	8	20	8		40	28
29	Heating/ Ventilating			1998	592	30	20	30		94	29
30	5 - Heater W/Adapters			1999	2,269	227	10	227		756	30
31	Repair Water Leak -Kitchen			2000	1,334	67	20	67		172	31
32	Repair water Line - Booster Heater			2000	986	49	20	49		127	32
33	See Attached 12.1 Supplemental					69,276			(69,276)		33
34	30 - Amp Filters, W/G System & Use Tax			2001	243	24	10	24		47	34
35	Wanderguard System			2001	6,263	626	10	626		1,200	35
36	Use Tax Wanderguard System			2001	58	6	10	6		11	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	5: Thru Wall Heat/Cool Units	2001	\$ 2,131	\$ 426	5	\$ 426	\$	\$ 568	37
38	Use Tax 5: Thru Wall Heat/Cool Units	2001	149	30	5	30		40	38
39	3 Ton Condenser, East Wing & Use Tax	2001	861	57	15	57		86	39
40									40
41	Win Freezer Condenser Instl	2002	3,021	218	15	218		218	41
42	Instl Grease Interceptor	2002	4,871	264	20	264		264	42
43	Wanderguard System & Use Tax	2002	6,227	1,038	10	1,038		1,038	43
44	CR Inc # 1000017826/ discount	2002	(22)	(3)	10	(3)		(3)	44
45	CR Inc # 1000017900 W/G system Discount	2002	(349)	(55)	10	(55)		(55)	45
46	Maglock Brackets	2002	151	25	10	25		25	46
47	Maglock Brackets	2002	151	25	10	25		25	47
48	CR Inv # 10015138 Corby Push	2002	(95)	(16)	10	(16)		(16)	48
49	Wanderguard System & Use Tax	2002	1,268	201	10	201		201	49
50	Cr -Labor charge Wanderguard	2002	(1,200)	(90)	10	(90)		(90)	50
51	Charge Excess Discount Wanderguard	2002	52	8	10	8		8	51
52	4: Heat/Cool Units 7 Use Tax	2002	1,959	229	5	229		229	52
53	Rplc 5 ton AirHandler, Condenser	2002	6,746	281	10	281		281	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,609,502	\$ 154,672		\$ 85,396	\$ (69,276)	\$ 699,713	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$425,975	\$43,863	\$43,863	\$	var	\$248,321	71
72	Current Year Purchases	14,632	1,803	1,803		var	1,803	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$440,607	\$45,666	\$45,666	\$		\$250,124	75

D. Vehicle Depreciation (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets					1	2	
		Reference				Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)				\$3,100,355	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$200,338	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$131,062	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$(69,276)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$949,836	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 1996	\$1,583	\$79	\$349	86
87	O/H Allocation 1996	568	28	119	87
88	O/H Allocation 1997	277	14	78	88
89	O/H Allocation 1997	965	48	244	89
90					90
91	TOTALS	\$3,393	\$169	\$790	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease.
- 

9. Option to Buy:
- ☐ YES☒ NO
- Terms:
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$3,611
- Description: Copier, tools, etc. - see attachment Page 14.1

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	92 hrs	\$ 1,988		\$ 22	92	\$ 2,010	1	
2	Licensed Speech and Language Development Therapist	10a	374 hrs	11,146		11	374	11,157	2	
3	Licensed Recreational Therapist		hrs						3	
4	Licensed Physical Therapist	10a	1968 hrs	40,289		376	1,968	40,665	4	
5	Physician Care		visits						5	
6	Dental Care	39	visits						6	
7	Work Related Program		hrs						7	
8	Habilitation		hrs						8	
9	Pharmacy	39	# of prescrpts			95,624		95,624	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						10	
11	Academic Education		hrs						11	
12	Exceptional Care Program								12	
13	Other (specify):								13	
14	TOTAL			\$ 53,423	\$	\$ 96,033	2,434	\$ 149,456	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,100	\$	1
2	Cash-Patient Deposits	29,757		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	868,141		3
4	Supply Inventory (priced at )	10,025		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 909,023	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	110,000		13
14	Buildings, at Historical Cost	438,825		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	109,389		16
17	Accumulated Depreciation (book methods)	(26,700)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1	110,277		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 741,791	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,650,814	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 38,465	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,844		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,758		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,413		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See attached Schd 17.1	40,739		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 180,219	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See attached Schd 17.1	147,015		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 147,015	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 327,234	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,323,580	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,650,814	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,936,645)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,936,645)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,454,030	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,454,030	17
	B. Transfers (Itemize):		
18	Fresh Start Acctg Due to Bankruptcy	1,806,195	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,806,195	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,323,580	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,006,067	1
2	Discounts and Allowances for all Levels	(945,264)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,060,803	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	381,374	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 381,374	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,587	13
14	Non-Patient Meals	3,228	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	147,774	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,509	19
20	Radiology and X-Ray	1,365	20
21	Other Medical Services	3,118	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 171,581	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Receipts		28
28a	Miscellaneous Receipts	(150)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (150)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,613,608	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	474,529	31
32	Health Care	1,026,410	32
33	General Administration	588,046	33
B. Capital Expense			
34	Ownership	(1,082,381)	34
C. Ancillary Expense			
35	Special Cost Centers	112,459	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,159,578	40
41	Income before Income Taxes (line 30 minus line 40)**	1,454,030	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,454,030	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,982	2,123	\$ 42,492	\$ 20.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,915	7,407	122,799	16.58	3
4	Licensed Practical Nurses	10,813	11,582	161,058	13.91	4
5	Nurse Aides & Orderlies	45,510	48,747	451,595	9.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,435	2,625	58,529	22.30	7
8	Rehab/Therapy Aides	1,824	1,967	41,425	21.06	8
9	Activity Director	1,925	2,072	19,442	9.38	9
10	Activity Assistants	1,623	1,746	10,421	5.97	10
11	Social Service Workers	1,698	1,776	16,379	9.22	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,108	28,498	13.52	13
14	Head Cook	5,671	6,010	51,719	8.61	14
15	Cook Helpers/Assistants	4,959	5,255	35,993	6.85	15
16	Dishwashers					16
17	Maintenance Workers	3,349	3,449	41,357	11.99	17
18	Housekeepers	9,431	9,792	65,844	6.72	18
19	Laundry	4,227	4,626	28,145	6.08	19
20	Administrator	1,991	2,170	64,638	29.79	20
21	Assistant Administrator					21
22	Other Administrative	1,604	1,748	20,942	11.98	22
23	Office Manager					23
24	Clerical	1,604	1,748	16,030	9.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,645	1,766	14,607	8.27	31
32	Other Health Care MCare Coord/ Case Mgt					32
33	Other(specify) Mkting & Transp	1,933	2,081	32,932	15.83	33
34	TOTAL (lines 1 - 33)	113,128	120,798	\$ 1,324,845 *	\$ 10.97	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	131	\$ 5,238	1 - 3	35
36	Medical Director	144	6,000	9 - 3	36
37	Medical Records Consultant	7	351	10-3	37
38	Nurse Consultant	242	11,213	10- 7	38
39	Pharmacist Consultant	75	3,904	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	3,326	11 - 3	44
45	Social Service Consultant	66	3,610	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	725	\$ 33,642		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	10 - 3	50
51	Licensed Practical Nurses	0	0	10 - 3	51
52	Nurse Aides	0	0	10 - 3	52
53	TOTAL (lines 50 - 52)		\$		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Steve L. Johnson	Adminstrator	100	\$ 58,298	Workers' Compensation Insurance		\$ 32,820	IDPH License Fee	\$
Tonya M. Hackney	Adminstrator	100	1,123	Unemployment Compensation Insurance		20,218	Advertising: Employee Recruitment	5,464
Margaret F. Bartolomucci	Adminstrator	100	14	FICA Taxes		97,730	Health Care Worker Background Check (Indicate # of checks performed _____)	2,822
				Employee Health Insurance		96,488	Other Licenses Fees	879
				Employee Meals			Dues	3,968
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension/Retirement		1,054		
				Insurance Life		1,797	Home Office Allocation	446
				Other Benefits		3,599	Total Advertising	4,510
				Home Office Allocation		0		
							Less: Public Relations Expense	(117)
							Non-allowable advertising	(4,394)
							Yellow page advertising	( 0 )
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) \$ 59,435				TOTAL (agree to Schedule V, line 22, col.8) \$ 253,705			TOTAL (agree to Sch. V, line 20, col. 8) \$ 13,579	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$ 0
							In-State Travel	11,870
							Home Office Allocation	5,772
							Seminar Expense	1,513
							Entertainment Expense	(19)
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement) \$				TOTAL \$			TOTAL (agree to Sch. V, line 24, col. 8) \$ 19,136	
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
Legal (SEE ATTACHED)	Legal Fees		1,408					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) \$ 1,408								

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**



Facility Name & ID Number		Nature Trail HealthCare Center		STATE OF ILLINOIS	#	0045765	Report Period Beginning:	01/01/2002	Ending:	12/31/2002	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>							
	If YES, give association name and amount.			<u>Illinois HealthCare Association - \$ 3,977</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>No</u>							
	If YES, have these costs been properly adjusted out of the cost report?			<u>N/A</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>							
	If YES, what is the capacity?			<u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>							
	What was the average life used for new equipment added during this period?			<u>10</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>3,814</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>							
	If YES, give effective date of lease.			<u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>x</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES NO <u>x</u>							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.			\$ <u>40,515</u>							
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			<u>No</u>							
	If YES, attach an explanation of the allocation.										
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			<u>No</u>							
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$ <u>0</u>							
	Has any meal income been offset against related costs?			<u>Yes</u>							
	Indicate the amount.			\$ <u>1,645</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			<u>No</u>							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>0</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training?			<u>N/A</u>							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>No</u>							
	Firm Name:			<u>N/A</u>							
	The instructions for the cost report require that a copy of this audit be included with the cost report.										
	Has this copy been attached?			<u>N/A</u>							
	If no, please explain.			<u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			<u>Yes</u>							
	Attach invoices and a summary of services for all architect and appraisal fees.										

STATE OF ILLINOIS

Facility Name & ID Number

Nature Trail HealthCare Center

#

0039586

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	16,635
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service <> Default <> Physical Plant	2,942
	19,577

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over \$2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Report Period:      Beginning:      01/01/2002      Page -3.2  
Ending:      12/31/2002

Facility Name & ID Number      Nature Trail HealthCare Center      #      0039586

Meals - adjustment

23,868	Days ( Total Patient days)
3	Mult (3 meals a day)
71604	Sub total
1283	meals to employess (reported by facility)
72887	Add Sub
93,456	Divide -Pg 3, line 2, column 2
1.28	Cost per day
1.28	Cost per day
1283	mult - meal to employees
1,645	= adjust for pg 2, line 2, column2

STATE OF ILLINOIS

Report Period:      Beginning:      01/01/2002      Page -4.1  
Ending:      12/31/2002

Facility Name & ID Number      Nature Trail HealthCare Center      #      0039586

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

<u>Ownership - Line 36</u>	<u>Amount</u>
Fresh Start Acctg Adj <> Bankruptcy Exp Acq <> Cost Non Overhead	(1,150,182)
Home Office - Depreciation	5,157
Home Office -Property taxes	153
	<u>(1,144,872)</u>

<u>Ancillary Expenses - Line 43 -Column 2</u>	<u>Amount</u>
Ancillary Supplies <> Default <> Laboratory	0
	<u>0</u>

<u>Ancillary Expenses - Line 43 -Column 3</u>	<u>Amount</u>
Contract Svcs - Chgbl <> Default <> Laboratory	3,704
Contract Svcs - Chgbl <> Default <> X/Ray	1,151
Professional Services Chgble <> Default <> X/Ray	0
Professional Services Chgble <> General / Other <> X/Ray	0
	<u>4,855</u>

STATE OF ILLINOIS

Facility Name & ID Number: Nature Trail HealthCare Center # 0045765

Related Illinois Nursing Homes  
as of  
12/31/2002

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	Dixon HealthCare Center	0040865
	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HeathCare Center	0037689
	Montebello HeathCare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HeathCare Center	0039503
	Parkway HealthCare Center	0040857
	Mariner Health of Westchester	0042374

STATE OF ILLINOIS

Facility Name & ID Number      Nature Trail HealthCare Center      #      0039586

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIIES

Line 9

OTHER CURRENT ASSETS:      AMOUNT

Total	0	Difference
Reconcile with schedule XV, line 9:	0	0

Line 23

OTHER NON-CURRENT ASSETS:

Asset Clearing <> Default-Prod <> Default-Dept	-	
Asset Clearing <> Default <> Realty	-	
Asset Clearing <> Capital Expenditures <> Realty	-	
Asset Clearing <> Fresh Start Valuation <> Realty	-	
Asset Clearing <> PS AM Capital Expenditures <>FS Realty	-	
Asset Clearing <> FAS 121 Impairment Valuation <> Realty	-	
Other Assets <> Rfndable Deposits-Int Bearing <> Default	-	
Excess Reorganized Value <>Excess Reorg Value <> Default	110,000	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	277	
Total	110,277	Rounding to bal page Difference
Reconcile with schedule XV, line 23:	110,277	(0)

Line 36

OTHER CURRENT LIABILITIES:      AMOUNT

Misc Dedctns - Employee <> Other Decductions <> Default	-	
Accruals - Insurance <> Self Funded Ins Accr <> Default	(37,602)	
Accruals - Insurance <> Basic Life <> Default	(613)	
Accruals - Insurance <> Lt Dsbilty <> Default	(106)	
Accruals - Insurance <> Executive Supp Life <> Default	(88)	
Accruals - Insurance <> Short Term Disability <> Default	(88)	
Accruals - Insurance <> Dependent Life <> Default-Dept	(12)	
Accruals - Insurance <> Accidental Death Dismemberment <> Defa	(4)	
Accruals - Insurance <> NES Insurance <> Default-Dept	(2,125)	
Misc Dedctns - Employee <> Miscellaneous <> Default	(102)	
Total	(40,739)	Difference
Reconcile with schedule XV, line 36:	(40,739)	0

Line 43

OTHER NON-CURRENT LIABILITIES::

Intercompany - Revolver <> Default <> Default	147,015	
Total	147,015	Difference
Reconcile with schedule XV, line 43:	147,015	(0)

Facility Name & ID NumberNature Trail HealthCare Center#0039586

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	0

Total0Difference

Reconcile with schedule XVII, line 28:

00

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	150
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-

Total150Difference

Reconcile with schedule XVII, line 28a:

150(0)